MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF PERSONNEL

WORK ADJUSTMENT/ACCOMMODATION REQUEST

Complete and submit to the Office of Personnel along with the Medical Information for Work Adjustment/Accommodation Request (form PF-43). This information will be filed in employees' confidential medical files.

EMPLOYEE NAME (PRINT)	SOCIAL SECURITY NUMBER	DATE

JOB TITLE	WORK LOCATION	WORK TELEPHONE NUMBER

1. Identify and describe the physical or mental disability, illness, condition or disease which is the basis for your request for accommodation(s) from the Department.

2. Identify and describe the functions of your job which you are unable to perform without accommodation(s) from the Department.

3. Identify and describe the assistance needed to enable you to perform the essential functions of your job (e.g., special equipment, changes in the physical layout of the job, etc.). If requesting equipment, please attach a picture, description, cost information, where equipment can be purchased, etc.

4. Identify and describe any special methods, skills or procedures which will enable you to perform the functions of your job.

5. Identify and describe equipment, aids, or services that you are willing to provide and utilize.

EMPLOYEE SIGNATURE ▶	DATE	HOME TELEPHONE

TO BE COMPLETED BY THE OFFICE OF PERSONNEL

Request(s) for adjustments/accommodations that are approved including anticipated time frame(s) for employee to receive such:

Request(s) for adjustments/accommodations that are not approved and reason(s):

Other options considered and approved/comments:

ACCOMMODATION AUTHORIZED BY ▶	DATE

IF APPLICABLE, EXPENDITURE AUTHORIZED BY	DATE

COST CENTER TO BE CHARGED	APPROXIMATE AMOUNT